MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03692

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place): 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 30 Maryland Avenue

3. NAME OF DECEASED (Type or Print): (First) Bertha (Middle) Beerbower (Last) BARE

4. DATE OF DEATH: (Month) 4 (Day) 24 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: 1-3-1876

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher Public school

10b. KIND OF BUSINESS OR INDUSTRY: Teacher

11. BIRTHPLACE (State or foreign country): Winterset, Iowa

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Samuel Beerbower

14. MOTHER'S MAIDEN NAME: Nancy Jane Huggins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) STENOSIS, BILE DUCT, COMMON — Interval Between Onset and Death: 8 months

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

155 X
46 f

(b) CALCULUS, GALLBLADDER

(c) ADENOCARCINOMA, COMMON BILE DUCT

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: JAUNDICE

19a. DATE OF OPERATION: 11-15-49

19b. MAJOR FINDINGS OF OPERATION: Obstruction, Common Bile Duct; Tumor Mass; Gallstones

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - - -

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): - - - -

RECEIVED
APR 28 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

03693

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY a a. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY a a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural give location) 1312 West St.

3. NAME OF DECEASED (Type or Print): (First) Samuel (Middle) J (Last) Brooke
4. DATE OF DEATH: (Month) 4 (Day) 8 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: Sept 8th 1864
9. AGE last birthday: 85 yrs. If under 1 year: Months Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Savings Bank (Cashier)
10b. KIND OF BUSINESS OR INDUSTRY: Savings Bank
11. BIRTHPLACE (State or foreign country): a a Co Md
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Samuel L. Brooke
14. MOTHER'S MAIDEN NAME: Elizabeth Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Isaac J. Yates Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 422.1 Immediate cause | (a) Myocarditis Chr. + Myocardial Insufficiency | 3 years |
| 932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) Arteriosclerosis | Several years |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1949, to April 8, 1950, that I last saw the deceased alive on April 9, 1950, and that death occurred at P P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Hugh C Boyle M. D Annapolis Md 4-8-50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE THEREOF 4-11-50 NAME OF CEMETERY OR CREMATORY Christ Church Yard LOCATION (City, town, or county) West River (State) a a Co Md

DATE REC'D BY LOCAL REG. April 10, 1950
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR John W. Yates. Son ADDRESS Annapolis Md.

15680

RECEIVED
APR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03694

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A43

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville; LENGTH OF STAY (In this place): 11 years 2 mos; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Balt. City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore; STREET ADDRESS (If rural, give location): 1413 McCulloh Street

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) (Last) Brown

4. DATE OF DEATH: (Month) 4/10/50 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: ~~about 1890~~ not known

9. AGE last birthday: 59(?) yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Brown

14. MOTHER'S MAIDEN NAME: Mary Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ~~*********~~

16. SOCIAL SECURITY NO.: ~~*********~~

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Disease — known since 3/26/50

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — (c) Epilepsy with Psychosis — known since 2/10/39

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none (CITY OR TOWN): none (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While at Work ☐ none

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 2/10/39, 19..., to 4/10/50, 19..., that I last saw the deceased alive on 4/10/50, 19..., and that death occurred at 3:00P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M.D. ADDRESS: Crownsville, Md. DATE SIGNED: 4/10/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: 4/13/1950 NAME OF CEMETERY OR CREMATORY: Mt. Auburn LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: 4/12/50 REGISTRAR'S SIGNATURE: H.W. Hedrick

24. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1631 David Hill ave.

Item 6: Birth cer. on file aa Co 7/14/49 - 2 5/10/50

MARYLAND STATE DEPARTMENT OF HEALTH

03695

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 1 hour
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural give location) Route # 2

3. NAME OF DECEASED (Type or Print) (First) LAURA (Middle) ELIZABETH (Last) BROWN
4. DATE OF DEATH (Month) APR (Day) 16 (Year) 1950 / 1949

5. SEX female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 7/14/49
9. AGE last birthday yrs. If under 1 year Months 9 Days 2 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME Daniel T. Brown
14. MOTHER'S MAIDEN NAME Elizabeth Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Elizabeth Chase Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Pneumococcus Meningitis | 2 days |
| 491x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 107 | (b) Broncho-Pneumonia | 1 week |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 4-17-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Apr. 17/50 NAME OF CEMETERY OR CREMATORY Franklin Cem LOCATION (City, town, or county) Churchton (State) Md.

DATE REC'D BY LOCAL REG. April 19, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis Md

1-0-7-14-9-17-12-40-R

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
APR 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03696

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 18 East St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 18 East

3. NAME OF DECEASED (Type or Print): (First) Eliza (Middle) G. (Last) Cannon

4. DATE OF DEATH: (Month) 4 (Day) 5 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 2-22-1869

9. AGE last birthday: 81 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Brooks

14. MOTHER'S MAIDEN NAME: Susan Brewer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: Mrs Flora Goss, Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X **Immediate cause** (a) Cancer of Stomach — Interval between onset and death: 6 or 8 mos

46b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Thrombocytopenic Purpura — about 3 mos

(c) General Debility — several mos.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mch 10, 1949, to April 5, 1950 that I last saw the deceased alive on April 4, 1950, and that death occurred at 3 40 A m., from the causes and on the date stated above.

SIGNATURE J. Alvin Purvis (Degree or title) M.D. ADDRESS Annapolis Md. DATE SIGNED 4/5/50

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) — DATE THEREOF 4-8-50 — NAME OF CEMETERY OR CREMATORY St Marys — LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. April 8, 1950 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR John W. Taylor Son ADDRESS Annapolis Md

RECEIVED
APR 14 1950
BUREAU OF S

03697

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 260

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Anne Arndel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt. City |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital | STREET ADDRESS (If rural, give location): not known |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) John | (Middle) William | (Last) Carroll | 4. DATE OF DEATH | (Month) 4/8/50 (Day) (Year) 19 |
| 5. SEX: male | 6. COLOR OR RACE: colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed | 8. DATE OF BIRTH: 6/4/89 | 9. AGE last birthday: 60 yrs. | If under 1 year: Months. Days; If under 24 hrs.: Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer | 10b. KIND OF BUSINESS OR INDUSTRY: Baker none | 11. BIRTHPLACE (State or foreign country): Somerset Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME: Moses Carroll | 14. MOTHER'S MAIDEN NAME: not known | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS: Hospital Records | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) General Paresis | known since 1/24/50 |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

025x

30b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: none | 19b. MAJOR FINDINGS OF OPERATION: none | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify): none | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none | |
| TIME OF INJURY (Month) (Day) (Year) (Hour): none m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? none |

22. I hereby certify that I attended the deceased from 1/24/50, 19....., to 4/8/50, 19....., that I last saw the deceased alive on 4/8/50, 19....., and that death occurred at 4:00 A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) ADDRESS | DATE SIGNED |
|---|---|---|
| Jacob Marycuston M.D. | Crownsville, Md. | 4/8/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 5-12-50 | NAME OF CEMETERY OR CREMATORY: John Wesley | LOCATION (City, town, or county) (State): Princess Anne, Md |
| DATE REC'D BY LOCAL REG.: 4/11/50 | REGISTRAR'S SIGNATURE: R. S. Johnson M.D. E. Fletcher Joyce Jr. | 24. FUNERAL DIRECTOR: William H James | ADDRESS: Princess Anne Md |

988XV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
APR 13 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: A15

Evidence for change of birth date shown on:

FILM No. G 106 MAY 25 1950

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

03698 22

Reg. Dist. No.

1. PLACE OF DEATH
COUNTY: Anne A rundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel
LENGTH OF STAY (in this place): Two years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hospital of Dist. Tr. School

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland D.C. — COUNTY: D.C. Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel Washington (Woods)
STREET ADDRESS (If rural, give location): District Training School 1705 Deaton St. N.E.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Allen | Morries | Cole | April | 28 | 19 50 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | Negro | Single | Aug. 11, 1941 | 8 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | Child | Washington, D.C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Allen Cole | Ida Mae------- Last name unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| NO | | None | Board of Public Welfare, D.C. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

480x

**Immediate cause** (a) Pneumonia, bilateral, lobular (broncho) — Interval between onset and death: 36 hrs.

**Antecedent cause(s)**

33a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Influenza — 4-5 days

(c) Mongolism — Entire life

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | 0 | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| 0 | 0 | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from 7-26-49, 19....., to 4-28....., 19...50 that I last saw the deceased alive on 4-28-....., 1950., and that death occurred at 6:30 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Benjamin E. Hodge | M.D. | District Train School Laurel, Md | 4-30-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 5-1-50 | Dist. Tr. School Cemetery | Anne Arundel | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| May 1-50 | Clara Hastup | Raymond L. Jones. | Laurel Md |

RECEIVED
MAY 6 1950
BUREAU OF S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03699

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park RFD. LENGTH OF STAY (in this place): 3 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cedarcrest Nursing Home | STREET ADDRESS (If rural, give location): |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) Peter (Middle) J. (Last) Crockett | | | | 4. DATE OF DEATH (Month) April (Day) 19 (Year) 1950 | |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced | 8. DATE OF BIRTH: 12/12/77 | 9. AGE last birthday: 72 yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown | 10b. KIND OF BUSINESS OR INDUSTRY: Unknown | 11. BIRTHPLACE (State or foreign country): Unknown | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME: ~~Unknown~~ Sauctian Crockett | | 14. MOTHER'S MAIDEN NAME: Margaret Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service) | 16. SOCIAL SECURITY No.: Unknown | 17. INFORMANT AND ADDRESS: Cedarcrest Nursing Home Records | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Lobar Pneumonia | 4 days |
| 450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) General Arteriosclerosis | ? |
| 108 | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Dec., 1949, to April 18, 1950, that I last saw the deceased alive on 4/18/50, 19....., and that death occurred at 8:30 A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Gustave H. Paulbeck | Glen Burnie, Md. | | 4/19/50. |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 4/24/50 | NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery | LOCATION (City, town, or county) (State): Balto., Md. |
| DATE REC'D BY LOCAL REG.: 4-24-50 | REGISTRAR'S SIGNATURE: h | 24. FUNERAL DIRECTOR: William Cook Inc. | ADDRESS: St Paul + Preston Sts |

XVX99

Dr. states cause OK as is

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

In Box #8.

MARYLAND STATE DEPARTMENT OF HEALTH

03700

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

BC Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS 292 West St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural give location) 3242 - KESWICK ROAD

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| DAVID | | DANNER | APR. | 6 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | JANY. 17. 1891 | 59 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman | Roller Skate Rink | Frederick Maryland | U. S. A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert T. Danner | Alice O. Burman |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | | Copy of Birth Certificate |

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset and Death |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary occlusion | Sudden |
| 94a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | unknown |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No X |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John M. Claffey | M.D. Deputy Medical Examiner | Annapolis Md. | 4/6/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 4-6-50 | MT. OLIVET CEMETERY | BALTIMORE, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| April 6, 1950 | | FRANK W. SEITZ | BALTIMORE, Md. |

47690

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
APR 14 1950
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

03701

Reg. Dist. No. 22

**1. PLACE OF DEATH:**

County: An. Ar.

City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Forest Ave.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: An. Ar.

City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Forest Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Walter S. Englehart

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W. | Married |

6.(b) Name of husband or wife: Virgie Harmann Englehart

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 5 | 17 | ..... hrs. ..... min. |

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Pipe Fitter

11. Industry or business: B. & O. R. R.

FATHER
12. Name: Englehart
13. Birthplace: Unknown

MOTHER
14. Maiden name: Francis Harman
15. Birthplace: Unknown

16. Informant: Mrs. Virgie Englehart

Address: Dorsey, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 27/50 (month) (day) (year)

Cemetery or crematory: Zion Cemetery

Location: Dorsey, Md.

18. Funeral director: Harry H. Witzke

Address: 4101 Edmondson Ave.

19. April 26 1950 (Date rec'd by registrar) Clara Hasleh Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23/50 19..... at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1949, to April 23 1950 and that I last saw him alive on April 23rd 1950

Immediate cause of death: Coronary Occlusion. — DURATION: Instant.

Due to: Coronary Thrombosis + Sclerosis — 1 yr.

Due to: Hypertension — 2 yr.

Other conditions: 420.1 94a

(Include pregnancy within 3 months of death)

Major findings of operations: ✓

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Frank Shipley, M. D. M. D. or other

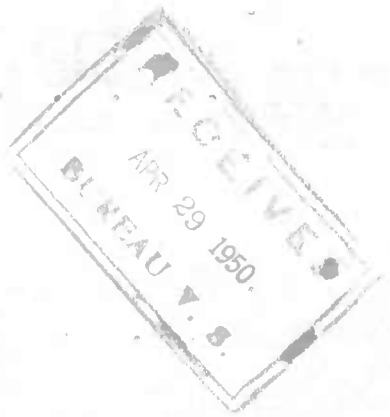
Address: Savage, Md. Date signed: 4/25/50

34247

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
APR 29 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

C3702

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 2 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
STREET ADDRESS (If rural, give location) 164 Lake Drive

3. NAME OF DECEASED (Type or Print) (First) Rudolph (Middle) (Last) Errath
4. DATE OF DEATH (Month) April (Day) 27 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH Oct 17, 1880
9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10b. KIND OF BUSINESS OR INDUSTRY Westinghouse Electric Co
11. BIRTHPLACE (State or foreign country) Austria Hungary
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Frederick Errath
14. MOTHER'S MAIDEN NAME Mary Meier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Stella M. Nelson Shore Acres Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Pulmonary Tuberculosis, st. 7 | at least 3 yrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) ~~Ant~~ Severe hemorrhage | 14 hrs. |
| | (c) | |

002 X
13b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Cardio-Vascular Disease c̄ Dumpsmith 6 mos.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar, 1948, to April 27, 1950, that I last saw the deceased alive on 4/28, 1950, and that death occurred at 9:20 P m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 4/28/50

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF April 29, 1950
NAME OF CEMETERY OR CREMATORY McCormick
LOCATION (City, town, or county) Pittsburg (State) Penn.

DATE REC'D BY LOCAL REG. 4/29/50
REGISTRAR'S SIGNATURE A. W. Hedrick R.D.
24. FUNERAL DIRECTOR A. Howard Evans 1400 S Charles St ADDRESS

32635

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03763

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis. LENGTH OF STAY (in this place) 4 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY Anne Arundel.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis.
STREET ADDRESS (If rural give location) 4 Murray Avenue.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Benton (Last) EWALD
4. DATE OF DEATH: (Month) April (Day) 6 (Year) 1950

5. SEX: Male.
6. COLOR OR RACE: White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married.
8. DATE OF BIRTH: 4-21-89
9. AGE last birthday: 60 yrs. If under 1 year: Months 11 Days 15. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy.
11. BIRTHPLACE (State or foreign country): Virginia.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Steven EWALD
14. MOTHER'S MAIDEN NAME: Augusta REICH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) WW I & II
16. SOCIAL SECURITY NO.: None.
17. INFORMANT: Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 **Immediate cause** (a) Cerebral hemorrhage. — Interval Between Onset and Death: 3 days.

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Previous cerebro-vascular accidents. — 4 years.
(c) Arterial hypertension. — Years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 28 June, 19 46, to 6 April, 19 50, that I last saw the deceased alive on 6 April, 19 50, and that death occurred at 306 A.m., from the causes and on the date stated above.

SIGNATURE G.M. Davis (Degree or title) G.M. DAVIS, M.D. ADDRESS DATE SIGNED 6 April 1950

23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF 4-10-50 | NAME OF CEMETERY OR CREMATORY Naval Academy | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. April 8, 1950 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John M. Taylor Son | ADDRESS Annapolis Md.

60896

RECEIVED
APR 14 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 03764 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Laura (Middle) V. (Last) Ferrell

4. DATE OF DEATH (Month) Apr (Day) 23 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Feb 10, 1857

9. AGE last birthday 93 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY Never worked

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Ferrell

14. MOTHER'S MAIDEN NAME Susan Cameron

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Dept of Welfare Baltimore Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) General Arterio-Sclerosis | ? |
| 450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Senility | ? |
| 97 | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 4/1/50, 19....., to 4/21, 1950, that I last saw the deceased alive on 4/21/50, 19....., and that death occurred at 4:15 A.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Faucher MD (Degree or title) ADDRESS Glen Burnie Md DATE SIGNED 4/23/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 4/26/50

NAME OF CEMETERY OR CREMATORY St Peters

LOCATION (City, town, or county) Baltimore Md (State)

DATE REC'D BY LOCAL REG. 4-25-50

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR William Cook Inc 1217 St Paul St ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for change of age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03765

FILM No. G 12[illegible] MAY 9 1950

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Parole

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, Md.
STREET ADDRESS (If rural give location): Parole,

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| James | | Fisher | 4 | 29 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | | 8-5-1908 | ~~42~~ 41 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Parole Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Salamon Fisher | Mary |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT |
|---|---|---|
| no | | Priscilla Fisher |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Acute Coronary Thrombosis — 1 hr.

431 X 94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Myocardial

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from (Apr 29), 19 50, to (Apr 29), 19 50, that I last saw the deceased alive on (Apr 29), 19 50, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| R. T. Richardson M.D. | Annapolis, Md. | 5/1/50 |

| 23. BURIAL, CREMATION, REMOVAL, OTHER | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | May 3, 1950 | Best Gate Cemetery | Parole AA | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 21. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| May 2, 1950 | [signature] | William Reese 2nd. | 108 Washington Annapolis, Md. |

98899

RECEIVED
MAY 3 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

03706

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: ANNE ARUNDEL · STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: GLEN BURNIE
LENGTH OF STAY (in this place): 3 WEEKS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 214 SECOND AVE. S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: MARYLAND · COUNTY: ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: PASADENA. (RURAL)
STREET ADDRESS (If rural give location): MOUNTAIN ROAD (JACOBSVILLE)

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) R (Last) FITZHUGH.

4. DATE OF DEATH: (Month) APRIL (Day) 14 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: DEC. 13, 1875

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): ANNE ARUNDEL COUNTY, MD

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN SCOTT

14. MOTHER'S MAIDEN NAME: MARGARET OSBOURNE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: JOHN W. HALL, SR 214 SECOND AVE S.W GLEN BURNIE, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Acute myocardial infarction — 1 hours

940a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) obesity — 25 years
(c) arteriosclerosis — 10-20 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. influenza - March 1950

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 10, 1950, to April 14, 1950, that I last saw the deceased alive on April 9, 1950, and that death occurred at 6:55 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Randall M. McLaughlin MD | RFD 5 Box 347 Pasadena, Md. | April 14, 1950

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL | DATE THEREOF: April 17 1950 | NAME OF CEMETERY OR CREMATORY: MT. CARMEL | LOCATION (City, town, or county) (State): MOUNTAIN RD., A.A. COUNTY MD

DATE REC'D BY LOCAL REG. 4/15/50 | REGISTRAR'S SIGNATURE: L. J. DeAlba | 24. FUNERAL DIRECTOR: Thomas W. Singleton | ADDRESS: Glen Burnie, Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
APR 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

P3767

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anarundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 15 da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Anarundel Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davisonville
STREET ADDRESS (If rural give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Essie | Viola | Ford | 4 | 25 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | Col | Widowed | 4/9/1897 | 53 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Res | Md Lydia Boarman | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edward Robinson | Lydia Boarman |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | — | Armond Ford |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 443x Immediate cause | (a) Cerebral Hemorrhage | 9 days |
| 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardio-Vascular Disease | 9 days |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

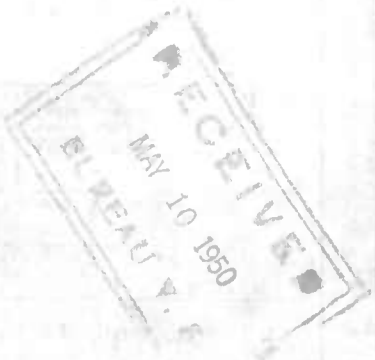
22. I hereby certify that I attended the deceased from 4-15-, 1950 to 4-25-, 1950, that I last saw the deceased alive on 4-25-, 1950, and that death occurred at 11:50 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| James R. Stanton | M.D. | Annapolis, Md. | 4-25-50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 4/28/50 | Price Chapel | LaPlata, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 4-26-50 | [illegible] | Hunt & Ryon | Waldorf, Md. |

Dr. Wm. J. French


RECEIVED
MAY 10 1950
BUREAU

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03768

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY: Garland Park Ferndale MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Ferndale COUNTY: A.A. Co |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie — LENGTH OF STAY (in this place): 30 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie Md. |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: None | STREET ADDRESS (If rural give location): 320 Broadview Blvd. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Ama | (Middle) (FRANKLIN) | (Last) Franklyn | 4. DATE OF DEATH | (Month) April (Day) 17 (Year) 1950 |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: June 1863 | 9. AGE last birthday: 86 yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10b. KIND OF BUSINESS OR INDUSTRY: Whoms | 11. BIRTHPLACE (State or foreign country): Carroll Co. Maryland | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: George Batson | 14. MOTHER'S MAIDEN NAME: Mary Stephen | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no | 16. SOCIAL SECURITY No.: None | 17. INFORMANT: Mrs. Agnes Franklyn (FRANKLIN) | | | |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic Valvular Disease of the Heart | 10 yrs. |
| 446x Antecedent cause(s) 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension & Chronic Interstitial Nephritis | 10 yrs. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION: — | 20. AUTOPSY? Yes ☐ No ☒ |

| | | | | |
|---|---|---|---|---|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify): no | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — | (CITY OR TOWN): — | (COUNTY): — | (STATE): — |
| TIME OF INJURY (Month) (Day) (Year) (Hour): — — m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? — | | |

22. I hereby certify that I attended the deceased from ....., 1940, to April 17, 1950, that I last saw the deceased alive on April 17, 1950, and that death occurred at 4 P. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| James S. Bellingolsa | M.D. | 108 Central Ave. Glen Burnie Md | April 17, 1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 4/20/50 | Glen Haven | Glen Burnie Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 4/18/50 | A. W. Hedrick | William Cook Inc | 1214 St Paul St |

MARYLAND STATE DEPARTMENT OF HEALTH

03709

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5 Oklahoma Ter.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural give location) 5 Oklahoma Terrace

3. NAME OF DECEASED (Type or Print): (First) Jeannette (Middle) Dessez (Last) Furlong
4. DATE OF DEATH: (Month) 4 (Day) 12 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, DIVORCED. (Specify)
8. DATE OF BIRTH: 11-5-1873
9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leon Dessez
14. MOTHER'S MAIDEN NAME: Wilhelmina Gebhardt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Comdr. Frances M. Furlong USN Ret Annapolis Md

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Embolism, multiple arterial — 3-5 da

420.0 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Heart Disease with

932 (c) auricular fibrillation and hypertension - 5 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to April 1, 1950, that I last saw the deceased alive on Apr. 12, 1950, and that death occurred at ....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

G M Davis M.D. 4/13/50

23. ~~BURIAL~~, CREMATION, ~~REMOVAL (Specify)~~ — DATE THEREOF 4-13-50 — NAME OF CEMETERY OR CREMATORY Ft Lincoln — LOCATION (City, town, or county) Pri Geo Co. — (State) Md

DATE REC'D BY LOCAL REG. April 13, 1950 — REGISTRAR'S SIGNATURE W. O. Arnold — 24. FUNERAL DIRECTOR John W. Taylor Son — ADDRESS Annapolis Md.

VS. A15

RECEIVED
APR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

03710

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL Laurel; LENGTH OF STAY (in this place) 2yrs. 10mo 26d
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.
STREET ADDRESS (If rural, give location) 614 Trumbull St. ✓

3. NAME OF DECEASED (Type or Print): (First) Shirley (Middle) (Last) Good
4. DATE OF DEATH: (Month) April (Day) 15 (Year) 1950
5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Aug 22, 1942
9. AGE last birthday: 7 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: (put) George Clark
14. MOTHER'S MAIDEN NAME: Clara Elizabeth Good
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: D.T.S. Records Laurel, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Broncho pneumonia | 1 week |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Fibro ulcerative tuberculosis | 2 years |
| | (c) Mental deficiency with developmental anomalies (microcephaly), spastic quadriplegia, idiocy. | since birth |

002x
136

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9, 1947, to Apr. 15, 1950, that I last saw the deceased alive on May 14, 1950, and that death occurred at 8:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
James A. Alston, MD. District Training School, Laurel, Md. 4-15-50

23. BURIAL, CREMATION REMOVAL (Specify): DATE April 17-50; NAME OF CEMETERY OR CREMATORY: Dist Training School; LOCATION (City, town, or county): Laurel (Rural); (State): Md

DATE REC'D BY LOCAL REG.: April 17-50
REGISTRAR'S SIGNATURE: Clara Nasluh
24. FUNERAL DIRECTOR: Raymond Jones ADDRESS

RECEIVED
APR 20 1950
BUREAU V. S.

03711

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton, Md. LENGTH OF STAY (in this place) 18 Yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton, Md. |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Churchton, Md. | STREET ADDRESS (If rural give location) Churchton near Annapolis |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Sylvanus | (Middle) ------ | (Last) Gross | 4. DATE OF DEATH | (Month) 4/ (Day) 3 (Year) 1950 |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 5/13/1878 | 9. AGE last birthday 71 yrs. | If under 1 year Months / Days — If under 24 hrs. Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Farm ~~None~~ Grower | 11. BIRTHPLACE (State or foreign country) Jewell A. A. Co. Md. | 12. CITIZEN OF WHAT COUNTRY? -------- | | |
| 13. FATHER'S NAME Mac Gross | 14. MOTHER'S MAIDEN NAME Jane Dorsey | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ------- | 16. SOCIAL SECURITY No. | 17. INFORMANT Daisy Gross | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 177X Immediate cause | (a) Carcinoma of Prostate (Inoperable) | 1½ yrs. |
| 51b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) — | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from March, 1949, to April 3, 1950, that I last saw the deceased alive on April 3, 1950, and that death occurred at 12:21 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [signature] | [signature] | [signature] | 4/6/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 4/6/1950 | NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | LOCATION (City, town, or county) (State) Lothian A. A. Co. Md. |
| DATE REC'D BY LOCAL REG. April 6, 1950 | REGISTRAR'S SIGNATURE J. B. Dent April 8-50 | 24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son | ADDRESS 45 Northwest St. |

000 VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 10 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 34 years 5 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): Patient transferred from Bay View Hospital

3. NAME OF DECEASED (Type or Print): (First) Mamie (Middle) (Last) Hackett

4. DATE OF DEATH: (Month) 4/4/50 (Day) (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: about 1873 not known

9. AGE last birthday: 76 (?) yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Unk. none

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): xxxxxxxxxx

16. SOCIAL SECURITY NO.: xxxxxxxxxx

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of the Stomach — Interval between onset and death: known since 2/26/50

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Mental Deficiency with Psychosis — known since 10/29/15

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none — (CITY OR TOWN): none — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 10/29/15, 19..., to 4/3/50, 19..., that I last saw the deceased alive on 4/3/50, 19..., and that death occurred at 12:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Harpenter M.D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 4/4/50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE: 4/11/50 — NAME OF CEMETERY OR CREMATORY: Hospital — LOCATION (City, town, or county) (State): Crownsville Md

DATE REC'D BY LOCAL REGR. 4/11/50 — REGISTRAR'S SIGNATURE: E.T. Joyce Reg. Local — 24. FUNERAL DIRECTOR: Supt. Hospital — ADDRESS: Crownsville Md

32077

RECEIVED
APR 18 1950
BUREAU A. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

03713

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 916 Poplar St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural give location) 916 POPLAR St.

3. NAME OF DECEASED (Type or Print) (First) EMMA (Middle) JOSEPHINE (Last) HAGELIN

4. DATE OF DEATH (Month) APR. (Day) 26 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH Aug. 29, 1895
9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lower House Keeper
10b. KIND OF BUSINESS OR INDUSTRY Factory + Home
11. BIRTHPLACE (State or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Augustus Fink
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 150-01-1159
17. INFORMANT William R. Brinkley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ACUTE DILATATION of HEART

443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE

93d (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John N. Caffy M.D., Deputy Medical Examiner (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 4/26/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 4-28-50 NAME OF CEMETERY OR CREMATORY National LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. April 26, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis Md. ADDRESS

98844

RECEIVED
APR 28 1950
BUREAU V. S.

03714

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A.Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERNA PARK
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERNA PARK
STREET ADDRESS (If rural give location) Cypress Creek Rd.

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) CLAYTON (Last) HARDY

4. DATE OF DEATH (Month) APRIL (Day) 24 (Year) 1950

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S.
8. DATE OF BIRTH 1-1-47
9. AGE last birthday 3 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harry C. Hardy
14. MOTHER'S MAIDEN NAME Geraldine Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Carcinomatosis | 2 months |
| 180X 52a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Wilms Tumor | 4 months |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Dec. 5, 1949
19b. MAJOR FINDINGS OF OPERATION Wilms Tumor, right
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1949, to APRIL 24 1950, that I last saw the deceased alive on Apr. 20, 1950, and that death occurred at 2 15/h m., from the causes and on the date stated above.

SIGNATURE James R. Martin (Degree or title) MD. ADDRESS Annapolis, Md. DATE SIGNED Apr. 24, 1950

23. BURIAL, CREMATION REMOVAL (Specify) B.
DATE THEREOF 4-26-50
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) (State) Baltimore

DATE REC'D BY LOCAL REG. 4-25-50
REGISTRAR'S SIGNATURE L
24. FUNERAL DIRECTOR James L. McCully ADDRESS 130 E. Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03715

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arundel Village (Balto-25) LENGTH OF STAY (in this place) 3 1/1-5
HOSPITAL OR INSTITUTION OR STREET ADDRESS #5-309 - 4th St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arundel Village (Balto-25)
STREET ADDRESS (If rural, give location) 5-309 4th St.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Magdalene (Last) Henley

4. DATE OF DEATH (Month) April (Day) 19 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Aug. 10, 1945
9. AGE last birthday 4 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Warren G. Henley
14. MOTHER'S MAIDEN NAME Mary Magdalene King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS Warren G. Henley 5-309 - 4th St. Arundel Village

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Status Epilepticus

351 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Brain injury at birth,

87e (c) Spastic paralysis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/16, 1950, to 4/19, 1950, that I last saw the deceased alive on 4/18, 1950, and that death occurred at 7:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Samuel Rubin MD. ADDRESS 203 Patapsco DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-22-50
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) Glen Burnie (State) Md.

DATE REC'D BY LOCAL REG. 4/22/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR T. N. Singleton ADDRESS Glen Burnie

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 22 1950
BUREAU V. S.

03716

Evidence for addition in 18 shown on:

FILM No. G 126 JUN 9 1950

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
LENGTH OF STAY (in this place) 22 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 Fourth Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
STREET ADDRESS (If rural give location) 100 Fourth Ave

3. NAME OF DECEASED (Type or Print) (First) Albert (Middle) Herbert (Last) Holton

4. DATE OF DEATH (Month) April (Day) 2 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH February 12, 1889
9. AGE last birthday 61 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber
10b. KIND OF BUSINESS OR INDUSTRY Mitchell Co
11. BIRTHPLACE (State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George T Holton
14. MOTHER'S MAIDEN NAME Emma S Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Carrie Whetson (Sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Failure

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Probable coronary thrombosis (6/6/50 akc)

(c)

420.1
94a

INTERVAL BETWEEN ONSET AND DEATH: Instantly

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-2, 1950, to 4-2, 1950, that I last saw the deceased alive on ——, 19....., and that death occurred at 8 P m. approximate, from the causes and on the date stated above.

SIGNATURE (Degree or title) Norman Zimberg MD
ADDRESS 320 Potapsco Ave
DATE SIGNED 4-2-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-6-50
NAME OF CEMETERY OR CREMATORY Glen Haven
LOCATION (City, town, or county) (State) Glen Burnie

DATE REC'D BY LOCAL REG. April 5, 1950
REGISTRAR'S SIGNATURE Ida M. Whetson
24. FUNERAL DIRECTOR James L. McCauley
ADDRESS 80 E. Fort Ave.

348 99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 7 1950
BUREAU V. S.

M

03717

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 22 Gotts Court

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 22 Gotts Court

3. NAME OF DECEASED (Type or Print) (First) Victoria (Middle) (Last) Hunt

4. DATE OF DEATH (Month) April (Day) 29 (Year) 1950

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 1896
9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Anne Arundel Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Birdie Cromwell, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cardiac Failure | 1 day |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardio Vascular Disease | 2 yrs. |
| | (c) | |

443x
93d

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/15, 1950, to 4/29, 1950, that I last saw the deceased alive on 4/29, 1950, and that death occurred at 9 50 P m., from the causes and on the date stated above.

SIGNATURE Theodore H. Johnson Pres. (Degree or title) 40 ADDRESS Northern Street Annapolis, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF May 3, 1950
NAME OF CEMETERY OR CREMATORY Broadneck
LOCATION (City, town, or county) St. Margretts, (State) Md.

DATE REC'D BY LOCAL REG. May 3, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J.B. Johnson Annapolis Md ADDRESS P.O. Box 462

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAY 4 1950
BUREAU T. S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

VS. A15

T

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03718

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA Rural
LENGTH OF STAY (in this place) 1 YEAR
HOSPITAL OR INSTITUTION OR STREET ADDRESS ROUTE 5 BOX 257

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA RURAL
STREET ADDRESS (If rural, give location) ROUTE 5 Box 257

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) CATHERINE E. JAKOBSEN

4. DATE OF DEATH (Month) (Day) (Year) APRIL 22 1950

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED

8. DATE OF BIRTH 9-26-97

9. AGE last birthday 52 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE

11. BIRTHPLACE (State or foreign country) ANNAPOLIS MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BARNEY LYNCH

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS LEO ARCHAMBAULT, LAKESHORE, PASADENA, MD.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) | Carcinoma |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Uraemia | Cervix diagnosis |
| | (c) Carcinoma, Cervix, uteri | 9/27/49 |

171X
48a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION 10/19/49

19b. MAJOR FINDINGS OF OPERATION Carcinoma, Cervix, uteri

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/27, 1949, to 4/22, 1950, that I last saw the deceased alive on 4/21, 1950, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

SIGNATURE Gerald A. Gawin (Degree or title) M.D. ADDRESS 113 N. Monument St. Balto. Md. DATE SIGNED 4/22/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL DATE THEREOF APRIL 25, 1950. NAME OF CEMETERY OR CREMATORY GLEN HAVEN LOCATION (City, town, or county) GLEN BURNIE (State) MD

DATE REC'D BY LOCAL REG. 4/25 REGISTRAR'S SIGNATURE L. J. DeAlba 24. FUNERAL DIRECTOR Thomas W. Singleton, ADDRESS Glen Burnie, Md.

24255

RECEIVED
APR 27 1950
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03719

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: ANNE ARUNDEL

City or town: PASADENA P.O.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

TAR COVE

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: MD County: ANNE ARUNDEL

City or town: PASADENA P.O.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: - TAR COVE

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** IDA H. JOHANSON

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | MARRIED |

6.(b) Name of husband or wife: JOHN IVA JOHANSON

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): SEPT 8, 1877

8. AGE: Years: 72 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: CZECH SLOVAKIA (Town, county, and state)

10. Usual occupation: HOUSE WIFE

11. Industry or business

FATHER — 12. Name: JOHN HORKEY

13. Birthplace: —

MOTHER — 14. Maiden name: MARY MELCAS

15. Birthplace: —

16. Informant: JOHN IVA JOHANSON

Address: TAR COVE. A.A.Co. MD. PASADENA P.O.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 4/27/50 (month) (day) (year)

Cemetery or crematory: - MAGOTHY CHURCH CEM.

Location: JACOBSVILLE, MD.

18. Funeral director: JOHN F. DENNY, INC

Address: 715 LIGHT ST -30

19. 4-25 1950 L (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/23 1950 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/5 1948 to 4/23 1950 and that I last saw h.e.r. alive on 4/22 1950

| Immediate cause of death | DURATION |
|---|---|
| Heart Failure | 3 days |
| Due to: Arteriosclerotic Cardio-Vascular Disease | 10 years |
| Due to: Hypertensive Cardio-Vascular Disease | 10 years |
| Other conditions: Hemiplegia (Left) | 2 years |

(Include pregnancy within 3 months of death)

Major findings of operations: 443 X Date of op.

Autopsy results: 93d

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Riviera Beach, Md. Date signed: 4/23/50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

03720

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brown Woods N. Annapolis — LENGTH OF STAY (in this place) 32 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Browns woods N. Annapolis |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Browns Woods Residence | STREET ADDRESS (If rural give location) Browns Woods Residence |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) Elizabeth (Middle) (Last) Johnson | | | 4. DATE OF DEATH (Month) 4 / (Day) 18 / (Year) 50 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 11/13/ 1886 | 9. AGE last birthday 63 yrs. | If under 1 year Months Days / If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housemaid Domestic | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Mulberry Hill A.A. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? ---------- |
| 13. FATHER'S NAME James Little | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ------- | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Oliver Johnson | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151X

Immediate cause (a) Carcinoma of Stomach.

46b

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 3-27, 1950, to 4-18, 1950, that I last saw the deceased alive on 4-17-50, 19....., and that death occurred at 3:15 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| [signature] | [illegible] | 10 Carroll | 4-21-50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 4/21/50 | NAME OF CEMETERY OR CREMATORY Broad Neck Cemetery | LOCATION (City, town, or county) (State) Skidmore Maryland |
| DATE REC'D BY LOCAL REG. April 21, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son | ADDRESS 45 Northwest St |

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

03721

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 58 Spa Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 58 Spa Road

3. NAME OF DECEASED (Type or Print): (First) MARIE (Middle) (Last) JOHNSON

4. DATE OF DEATH: (Month) April (Day) 28 (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 4-2-1922

9. AGE last birthday: 28 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maid

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Wilson

14. MOTHER'S MAIDEN NAME: Mary Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: James Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

33/x **Immediate cause** (a) Subdural hematoma

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN): (COUNTY): (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: RS Fisher (Degree or title): M.D. ADDRESS: 700 Fleet Street DATE SIGNED: 4-29-50

23. BURIAL, CREMATION REMOVAL (Specify): ✓ DATE THEREOF: May 2, 1950 NAME OF CEMETERY OR CREMATORY: Brewer Hill Cemetery LOCATION (City, town, or county): Annapolis, AA (State): Md.

DATE REC'D BY LOCAL REG.: May 1, 1950 REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Wm. Reese 2nd ADDRESS: 108 Washington St. Annapolis, Md.

52086

RECEIVED
MAY 2 1950
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03722

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 45 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 18 Murry Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 18 Murry Ave.

3. NAME OF DECEASED (Type or Print) (First) LESTER (Middle) B (Last) LACEY
4. DATE OF DEATH (Month) (Day) (Year) 4-18-50 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 8-22-1877
9. AGE last birthday 72 yrs. If under 1 year Months 7 Days 26 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrican
10b. KIND OF BUSINESS OR INDUSTRY US Gov.
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William J. Lacey
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY No. none
17. INFORMANT AND ADDRESS William J. and Rush L. Lacey Annapolis, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of m.m. of cheek — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

144 X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

53

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/14, 1950, to 4/18, 1950, that I last saw the deceased alive on 4/18, 1950 and that death occurred at 4 10 P m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans, Md (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 4/19/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-21-50
NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery
LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. April 21, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

31497

RECEIVED
APR 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

03723

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville; LENGTH OF STAY (In this place) 2 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 214 - U.S.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville; STREET ADDRESS (If rural, give location) U.S. Route 214

3. NAME OF DECEASED (Type or Print): (First) SHARON (Middle) ELAINE (Last) LONG

4. DATE OF DEATH: (Month) Apr. (Day) 4 (Year) 1950

5. SEX: female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Mar. 29. 1948

9. AGE last birthday: 2 yrs. If under 1 year: Months 0 Days 6 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: not Known

14. MOTHER'S MAIDEN NAME: Mary Frances Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Mae Long

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s) 183 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) Davidsonville (COUNTY) A.A. (STATE) Md.

TIME OF INJURY: (Month) (Day) (Year) (Hour) Apr. 4 1950 6:45 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? Fell head-first in deep spring

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Jno M. Caffy (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 4/4/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 4-7-50 NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery LOCATION (City, town, or county) Glen Burnie, Md. (State)

DATE REC'D BY LOCAL REG. April 6, 1950 REGISTRAR'S SIGNATURE Received April 7. Jessie Smith

24. FUNERAL DIRECTOR: B. L. Hopkins and Son ADDRESS Annapolis Md.

RECEIVED
APR 10 1950
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03724

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton
LENGTH OF STAY (in this place): LIFE.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton
STREET ADDRESS (If rural, give location): —

**3. NAME OF DECEASED** (Type or Print): (First) Isabel (Middle) — (Last) Lowman

**4. DATE OF DEATH**: (Month) April (Day) 2 (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | | Mar 14, 1862 | 88 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Maryland | US |

**13. FATHER'S NAME**: William Redmiles

**14. MOTHER'S MAIDEN NAME**: Sis Kennick

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service): NO

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT AND ADDRESS**: Mrs Hattie Hood - Odenton.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| **Immediate cause** | (a) Uremia, Chronic Nephritis | 3 weeks. |
| 450.0 **Antecedent cause(s)** | | |
| 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized Arterio-sclerosis | 10 years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1947, to April 2, 1950, that I last saw the deceased alive on April 1, 1950, and that death occurred at 2:20 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Edward J Hewitt | M.D. | Gambrills Md | April 3, 1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 4-4-50 | Nickols Memorial | Odenton, A.A., Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 4/4/50 | L. J. Dillon | Thomas W. Singleton | |

RECEIVED
APR 7 1950
BUREAU T. S.

Evidence for change of birth date shown on:

FILM No. G 125 APR 18 1950

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

03725

Reg. Dist. No. 20

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo
LENGTH OF STAY (in this place): 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Mayo Road at Saves Corner

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland COUNTY: A. A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo
STREET ADDRESS (If rural, give location): Beverly Beach

3. NAME OF DECEASED (Type or Print): (First) ANTHONY (Middle) LE GRANGE (Last) MAYHEW
4. DATE OF DEATH: (Month) APR. (Day) 10 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Mar. 24, 1896
9. AGE last birthday: 57 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired D.C. Fire Dept
10b. KIND OF BUSINESS OR INDUSTRY: Fire Dept
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Joseph W. Mayhew
14. MOTHER'S MAIDEN NAME: Sarah Kelly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph A. Mayhew

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary occlusion | sudden |
| 94a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | several years |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): John M. Claffy M.D. ADDRESS: Deputy Medical Examiner Annapolis, Md. DATE SIGNED: 4/10/50

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF: 4/10/50
NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
LOCATION (City, town, or county) (State): Wash. D. C.

DATE REC'D BY LOCAL REG.: 4/10/50
REGISTRAR'S SIGNATURE: Amanda Dourney
24. FUNERAL DIRECTOR: Timothy Hanlon ADDRESS: 641-H St NE Wash D.C

Edward Collinson

98898

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
APR 13 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03726

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A13

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie; LENGTH OF STAY (in this place) 8 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 506 Theresa Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie,
STREET ADDRESS (If rural, give location) 506 Theresa Street

3. NAME OF DECEASED (Type or Print): (First) Benjiman (Middle) W. (Last) McLane

4. DATE OF DEATH: (Month) April (Day) 20, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 13, 1874

9. AGE last birthday: 75 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Chem. Ind.

11. BIRTHPLACE (State or foreign country): Brooklyn, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander McLane

14. MOTHER'S MAIDEN NAME: Racheal Mallonee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO. 213-01-9424 A.

17. INFORMANT AND ADDRESS: Carl W. McLane 512 Theresa St. Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 hrs.

46e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma colon (hepatic)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 7-5-49

19b. MAJOR FINDINGS OF OPERATION: Carcinoma colon

20. AUTOPSY? Yes ☐ No X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950 to 4-20, 1950 that I last saw the deceased alive on 4-20, 1950, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE: Charles R. MacDonald (Degree or title) ADDRESS: Glen Burnie, Md. DATE SIGNED: 4-21-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: April 24, 1950

NAME OF CEMETERY OR CREMATORY: Glen Haven

LOCATION (City, town, or county) (State): Glen Burnie, A. A. Co., Md.

DATE REC'D BY LOCAL REG. 4/22/50

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: Thomas W. Singleton, Glen Burnie, Md.

4961

RECEIVED
APR 22 1950
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03727

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville P.O.
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Watterbury, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville P.O.
STREET ADDRESS (If rural, give location): Watterbury

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) LEE (Last) MEADE

4. DATE OF DEATH: (Month) 4 (Day) 20 (Year) 50 19

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED.

8. DATE OF BIRTH: 4-3-1863

9. AGE last birthday: 87 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: DRY GOODS

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BROOKE MEADE

14. MOTHER'S MAIDEN NAME: MARY TALBOT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: ELLA M. MEADE — CROWNSVILLE MARYLAND (P.O.)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Thrombosis | 12 Hrs. |
| 420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d | (b) Generalized Arterio-sclerosis | 4 yrs. |
| | (c) Arterio-Sclerotic Heart Disease | 4 yrs. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1947, to April 20, 1950, that I last saw the deceased alive on April 18, 1950, and that death occurred at 7:55A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Edward J Hewitt | M.D. | Crownsville | 4-20-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 4-22-50 | BALDWIN MEMORIAL | MILLERSVILLE, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 4/21.50 | E.T. Joyce Local Reg. | B. L. HOPPING & SON | ANNAPOLIS, Md. |

27863

RECEIVED
APR 22 1950
BUREAU, V. S.

03728

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY ~~BALTO.~~ ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5210 DISNEY AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A. ~~BALTO.~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN
STREET ADDRESS (If rural, give location) 5210 DISNEY AVE.

3. NAME OF DECEASED (Type or Print) (First) THOMAS (Middle) W. (Last) MEAGHER

4. DATE OF DEATH (Month) APRIL (Day) 18 (Year) 1950

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 28, 1876
9. AGE last birthday 73 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker
10b. KIND OF BUSINESS OR INDUSTRY Contractor
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Mrs. Bertha Bunn

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Pulmonary Oedema | 2 hrs |
| 148x Antecedent cause(s) | (b) Generalized Carcinomatosis | 6 mos |
| 45f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Carcinoma Pharynx | 1 yr |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 12, 1950, to April 18, 1950, that I last saw the deceased alive on April 18, 1950, and that death occurred at 14/18/50 8:50 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Benjamin Berdiansky M.D. ADDRESS 5004 Ritchie Hwy DATE SIGNED 4/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4-22-50
NAME OF CEMETERY OR CREMATORY Cathedral
LOCATION (City, town, or county) (State) Baltimore

DATE REC'D BY LOCAL REG. 4/24/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR George H Forley Fulton Ave. ADDRESS Fayette St.

362V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 25 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03729

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY A. A. MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY ~~A. A.~~ |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Arundel Beach Cedarcrest Nursing Home | STREET ADDRESS ~~Colespring Home~~ (If not give location) 1901 N. Monroe ~~Coldspring Nursing Home~~ |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| LAURA | HATTIE | MILLER | Apr. 20, 1950 19 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year Months | Days | If under 24 hrs. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | single | Mar. 13, 1867 | 83 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired charwoman | unknown | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Carl A. Miller | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS |
|---|---|---|---|
| no | | no | Mrs. Fred Stromyer 2788½ Alameda |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Arterio-sclerotic heart disease | ? |
| 420.0 Antecedent cause(s) | (b) General Arterio-Sclerosis | ? |
| 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Senility | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | Yes ☐ No ☐ |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | | — |

22. I hereby certify that I attended the deceased from 4/14, 1950, to 4/30, 1950, that I last saw the deceased alive on 4/19/, 1950, and that death occurred at 1 A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Gustave H. Paulsen M.D. | | Glen Burnie, Md. | 4/21/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 4/22/50 | Loudon Park Cem. | Balto., Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 4/21/50 | B.W. Hedrick | Wm. J. Tickner & Sons | Balto. Md. |

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

2101 W. Coldspring Lane

Zone 9

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

03730

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington; STREET ADDRESS (If rural, give location) 54 New York Ave. N.E. ✓

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| SHIRLEY | MAY | NICHOLSON | APR. | 9 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | Widowed | (about 1895) | 54 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Housekeeper | Home | VIRGINIA | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| unknown | unknown. |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | | George W. Towles |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 420.1 Immediate cause | (a) Coronary occlusion | sudden |
| 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | unknown |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John N. Caffy | M.D. Deputy Medical Examiner | Annapolis, Md | 4/9/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 4-9-50 | | Washington D.C. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| April 9, 1950 | [signature] | W. W. Chambers | Washington D.C. |

RECEIVED
APR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03731

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 10.5.49-4.29.50; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Dorc.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge; STREET ADDRESS (If rural, give location) 305 High Street ✓

3. NAME OF DECEASED (Type or Print): (First) Samuel; (Middle); (Last) Nutter

4. DATE OF DEATH: (Month) April; (Day) 29; (Year) 1950

5. SEX: male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: March 2 1869

9. AGE last birthday: 80 yrs. If under 1 year: Months —; Days —; If under 24 hrs.: Hours —; Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): cook

10b. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Dorchester County Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ? (If year, give war or dates of service): ?

16. SOCIAL SECURITY No.: ?

17. INFORMANT AND ADDRESS: Mrs. Evelyn Davis 213 Ivy St, Chester, Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — Interval Between Onset and Death: Known to us since

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General Paresis — 10.5.49- to

(c) Psychosis with Arteriosclerosis — 4.29.1950.

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 10/5/49., 1949., to April 29, 1950., that I last saw the deceased alive on April 28., 1950, and that death occurred at 7 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob Marquette M.D. Crownsville State Hospital, Crownsville, Md.

23. BURIAL, CREMATION, REMOVAL (Specify): burial

DATE: May 3 1950

NAME OF CEMETERY OR CREMATORY: Waugh Cemetery

LOCATION (City, town, or county) (State): Cambridge Md.

DATE REC'D BY LOCAL REG. 4-30-50

REGISTRAR'S SIGNATURE: E.T. Joyce Local Reg.

24. FUNERAL DIRECTOR: Herbert M. St. Clair

ADDRESS: Cambridge, Md.

72071

RECEIVED
MAY 2 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

03732

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P. O. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rock Pt. Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P. O.
STREET ADDRESS (If rural, give location) Rock Pt. Rd.

3. NAME OF DECEASED (Type or Print): (First) BLANCHE (Middle) MAY (Last) OSBOURN
4. DATE OF DEATH: (Month) APRIL (Day) 21 (Year) 1950
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: May 27, 1872
9. AGE last birthday: 77 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John W. Plummer
14. MOTHER'S MAIDEN NAME: Clara V. Youse
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If year, give war or dates of service)
16. SOCIAL SECURITY No.: no
17. INFORMANT AND ADDRESS: Mrs. Emma Osbourn, Rock Pt. Rd., Pasadena Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Heart Failure | 4 days |
| 422.1 Antecedent cause(s) | | |
| 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerotic Cardio Vascular Disease | 8 years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/19, 1950, to 4/21, 1950, that I last saw the deceased alive on 4/20, 1950, and that death occurred at 8:55 A m., from the causes and on the date stated above.

SIGNATURE: J. Brady Smith, M.D. (Degree or title) | ADDRESS: Riviera Beach, Md. | DATE SIGNED: 4/21/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 4/24/50 | NAME OF CEMETERY OR CREMATORY: Greenmount Cem. | LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG.: April 22. 1950 | REGISTRAR'S SIGNATURE: R.W.

24. FUNERAL DIRECTOR: Wm. J. Tichner & Sons | ADDRESS: Balto Md.

03733

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural give location) 409 Fifth St.

3. NAME OF DECEASED (Type or Print) (First) Rose (Middle) W. (Last) Parkinson
4. DATE OF DEATH (Month) 4 (Day) 1 (Year) 1950

5. SEX F.
6. COLOR OR RACE W.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Aug 18-1872
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas J. Linthicum
14. MOTHER'S MAIDEN NAME Rosana McKarglin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs Robert E. Kindred Glen Burnie Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Generalized Carcinomatosis | 2-17-50 |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Primary Lumbar Ovary | 4-1-50. |
| | (c) | |

175x
49a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis generalized.

19a. DATE OF OPERATION NONE.
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-17, 1950, to 4-1, 1950, that I last saw the deceased alive on 4-1, 1950, and that death occurred at 6:15 P m., from the causes and on the date stated above.

SIGNATURE E. Linhardt (Degree or title) MD. ADDRESS Eastport - Maryland DATE SIGNED 4-2-50.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ DATE THEREOF Apr-4-1950 NAME OF CEMETERY OR CREMATORY St Annes LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. April 3, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03734

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.Naval Hospital, Anpls., Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 1023 West St., Annapolis, Md.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Henry (Last) PFEIFFER
4. DATE OF DEATH: (Month) April (Day) 24 (Year) 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9-27-1874
9. AGE last birthday: 75 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased JOHN PFEIFFER
14. MOTHER'S MAIDEN NAME: Deceased MARTHA WENK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Thrombosis, Cerebral, Vessel Undetermined — 8 hours

332 X Antecedent cause(s) (b) Cerebral Arteriosclerosis — Years

83b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis, Generalized — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work [ ] Not While At work [ ] | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 April, 1950, to 24 April, 1950, that I last saw the deceased alive on 24 April, 1950, and that death occurred at 1:10 A. m., from the causes and on the date stated above.

SIGNATURE G.M. DAVIS — (Degree or title) CDR, MC, USN — ADDRESS U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. — DATE SIGNED 4-24-50

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 4-26-1950 | NAME OF CEMETERY OR CREMATORY Ft Lincoln | LOCATION (City, town, or county) Bruce Pro Co | (State) Md

DATE REC'D BY LOCAL REG. April 25, 1950 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Taylor Son | ADDRESS

V2896

VS. 413

RECEIVED
APR 27 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03735

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sandy Point Ferry
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fruitland
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) (Last) PITTS

4. DATE OF DEATH: (Month) April (Day) 28, (Year) 1950

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 4/23/1914

9. AGE last birthday: 36 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): oysterman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Berlin, Md

12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Thomas Pitts

14. MOTHER'S MAIDEN NAME: Rachel (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 286-01-8241

17. INFORMANT: Effie Pitts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

8235 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

183 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: Bay

(CITY OR TOWN) Chesapeake Bay at Sandy Point Ferry, Md. (COUNTY) Anne Arundel (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY: April 27, 1950 11p.m.

INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR? slip Accidentally drove truck off South Ferry

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE: R.S. Fisher (Degree or title) M.D. ADDRESS: 700 Fleet St., Baltimore 2, Md. DATE SIGNED: April 29, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: May 3-50 — NAME OF CEMETERY OR CREMATORY: Mt Calvary — LOCATION (City, town, or county): Fruitland (State): Md.

DATE REC'D BY LOCAL REG.: April 30, 1950 — REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: [illegible] — ADDRESS: Annapolis Md.

42099

RECEIVED
MAY 3 1950
BUREAU U. S.

03736

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Waterbury Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Crownsville, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Sarah J. Poole

**3.(b) Social Security Number**

4. Sex: female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Henry Poole

6.(c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.): May, 10 1885

**8. AGE:** Years: 64 | Months | Days | If less than one day ___ hrs. ___ min.

9. Birthplace: West-River A A Co Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles Johnson.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maria, ?
15. Birthplace

16. Informant: Henry Poole

Address: Crownsville Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Apr. 16, 50
(month) (day) (year)

Cemetery or crematory: John Westley

Location: Waterbury

18. Funeral director: J. B. Johnson

Address: Annapolis Md

19. 4/15 1950 (Date rec'd by registrar) E. F. Joyce Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: April 12th 1950, at 5:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19 4/12

and that I last saw her alive on April 9th 1950

Immediate cause of death: Coronary, disease

Due to: Hemorrhage, brain

Due to: Hauterive Sclerosis

Other conditions: Hypertension, Paralysis

(Include pregnancy within 3 months of death)

DURATION

420.1

Major findings of operations: 94a

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? ___ (City or town) ___ (County) ___ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ___ Injured at work?

23. SIGNATURE: O. H. Mac Neuar
M. D. or other

Address: Millersville Md Date signed: 4/12-50

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 17 1950
U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03737

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport — LENGTH OF STAY (In this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 409 5th St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 409 5th St.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Sutton (Last) Price

4. DATE OF DEATH: (Month) April (Day) 5 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M

8. DATE OF BIRTH Dec. 27 1866

9. AGE last birthday 83 yrs. — If under 1 year: Months 3, Days 8, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw mill operator

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Price

14. MOTHER'S MAIDEN NAME Elizabeth Sutton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Hattie Riber (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 422.1 | Immediate cause | (a) Uremia | 2 days |
| 93d | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) arteriosclerotic cardiovascular disease | 6 mos. |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? — April

22. I hereby certify that I attended the deceased from 19 Sept, 1949, to April, 1950, that I last saw the deceased alive on April 1, 1950, and that death occurred at 3:05 P.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank M. Shipley | MD | 63 College Ave Annapolis | 4/5/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 4-8-50 | Davidsonville Methodist | Davidsonville, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| April 6, 1950 | [signature] | B. L. Hopkins and Son | Annapolis, Md. |

49609

RECEIVED
APR 11 1950
BUREAU V. S.

03738

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 331 Locust Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 331 Locust Ave.

3. NAME OF DECEASED (Type or Print) (First) THEODORE (Middle) R (Last) REUWER
4. DATE OF DEATH (Month) 4 (Day) 1 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 2-4-1887
9. AGE last birthday 63 yrs. If under 1 year Months 1 Days 27 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY locomotive engineer
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I
16. SOCIAL SECURITY NO. 214-05-2961
17. INFORMANT AND ADDRESS Mrs. Nathalie R. Reuwer 331 Locust Ave. Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177X Immediate cause (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months

51b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of the Prostate — 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 2/1/49
19b. MAJOR FINDINGS OF OPERATION Carcinoma of the Prostate
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/5/49, 19....., to 4/1/50, 19....., that I last saw the deceased alive on 4/1/50, 19....., and that death occurred at 3:00 A.M. m., from the causes and on the date stated above.

SIGNATURE Albert L. Friedman M.D. (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 4/1/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4-3-50
NAME OF CEMETERY OR CREMATORY Glen Haven Memorial
LOCATION (City, town, or county) (State) Glen Burnie, Maryland

DATE REC'D BY LOCAL REG. April 3, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Md.

32293

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

03739

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, Maryland
LENGTH OF STAY (in this place): 82 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport, Maryland
STREET ADDRESS (If rural, give location): 700 Chesapeake Avenue

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Howell (Last) RITTER

4. DATE OF DEATH: (Month) 4 (Day) 14 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1-29-1886

9. AGE last birthday: 64 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy R.E.T.

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: DECEASED Unknown

14. MOTHER'S MAIDEN NAME: DECEASED Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): WW I&II

16. SOCIAL SECURITY NO.: - - - - -

17. INFORMANT AND ADDRESS: Hospital Records

177
51b

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) MULTIPLE GENERALIZED METASTASIS FROM — Interval Between Onset and Death: 1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) CARCINOMA, PROSTATE — 3 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. MULTIPLE DECUBITI

19a. DATE OF OPERATION: - - - - - - -

19b. MAJOR FINDINGS OF OPERATION: - - - - - -

RECEIVED
FEB 18 1950

MARYLAND STATE DEPARTMENT OF HEALTH

03740

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D 3 | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Off Annapolis Roads Club Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (Rural give location) 1115 Court Drive

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) ANTHONY (Last) SAPPINGTON
4. DATE OF DEATH: (Month) APR. (Day) 21 (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | | 12-7-1903 | 46 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RIGGER U.S.N. ACADEMY | EXP. STATION | BALTIMORE MD | U.S.A. |

13. FATHER'S NAME: WALTER SAPPINGTON
14. MOTHER'S MAIDEN NAME: HELEN TRAVERS

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | — | HELEN NOVO - (DAUGHTER) |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carbon-monoxide poisoning

973.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the under lying cause last
1630 (b) Suicide

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffe (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 4/21/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF 4-24-50 | NAME OF CEMETERY OR CREMATORY SHERWOOD | LOCATION (City, town, or county) SHERWOOD Md. (State)

DATE REC'D BY LOCAL REG. April 24, 1950 | REGISTRAR'S SIGNATURE W. T. French | 24. FUNERAL DIRECTOR JOHN M. TAYLOR & SON | ADDRESS ANNAPOLIS MD.

496-W

RECEIVED
NOV 27 1950
ST. LOUIS U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03741

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
LENGTH OF STAY (in this place) 3 MO.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Co. Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural.
STREET ADDRESS (If rural, give location) Edgewater P.O.

3. NAME OF DECEASED (Type or Print) (First) Ollie (Middle) Sewell (Last)

4. DATE OF DEATH (Month) Apr (Day) 8 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH about 1887 Unknown
9. AGE last birthday 62 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset and Death |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary Thrombosis | 4 days |
| 94a | Antecedent cause(s) | (b) Arteriosclerosis | ? |
| | Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Smile

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/6, 1950, to 4/8, 1950, that I last saw the deceased alive on 4/7, 1950, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Maurice K Lawrence, Md
ADDRESS Annapolis, Md
DATE SIGNED 4/8/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4-10-50
NAME OF CEMETERY OR CREMATORY Edwards Chapel
LOCATION (City, town, or county) Parole, Md (State)

DATE REC'D BY LOCAL REG. 4-10-50
REGISTRAR'S SIGNATURE Edward Collenson
24. FUNERAL DIRECTOR T A Hardesty & Son
ADDRESS

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

RECEIVED
APR 14 1950
PL. HEAD V. S.

03742

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) Life | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 47 Fleet Street | STREET ADDRESS (If rural give location) 47 Fleet Street |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) Charles | (Middle) Henry | (Last) Simpkins | 4. DATE OF DEATH (Month) 4- | (Day) 2 | (Year) 50 19 |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 12/9/1875 | 9. AGE last birthday 74 yrs. | If under 1 year Months ~~Days~~ If under 24 hrs. ~~Hours~~ Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Utility (Funeral) | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Annapolis, Maryland | 12. CITIZEN OF WHAT COUNTRY? ----- | | |
| 13. FATHER'S NAME Jessie Simp kins | | 14. MOTHER'S MAIDEN NAME Sarah Blckstone | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year no. or unknown) Yes | (If yes, give war or dates of service) Spanish American - None 4/21/1898- 4/11/1899 | 16. SOCIAL SECURITY NO. | 17. INFORMANT Bessie Simpkins | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause (a) Cardiac Failure

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Mar 1, 1950, to April 2, 1950, that I last saw the deceased alive on ....., 19....., and that death occurred at 9 30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Theodore H. Johnson M.D.

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 4/7/1950 | NAME OF CEMETERY OR CREMATORY Br ewer Hill Cemetery | LOCATION (City, town, or county) (State) West St. Annapolis, Md. |
| DATE REC'D BY LOCAL REG. April 7, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR Mrs. Charles E. Hicks& Son- | ADDRESS 45 Northwe st St. |

49699

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03743

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole — LENGTH OF STAY (in this place) 4yrs. 4mos. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Parole postoffice | STREET ADDRESS (If rural give location) Parole postoffice |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Elizabeth | | Spriggs | 4 | 11 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Married | 2/11/1896 | 54 yrs. | 2 | | - | - |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic Cook & Housemaid | none | Anne Arundel Co. Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Franklin | Rebecca Harrod |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | none | Thomas Spriggs |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Coronary Thrombosis — 1 Day

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

94a

(b)

(c) Arterial Hypertension

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from 4/11/50, 19..., to 4/11/50, 19..., that I last saw the deceased alive on 4/11/50, 19..., and that death occurred at 8:10A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| R. D. Richardson | M.D. | Annapolis | 4/13/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 4/16/50 | Chews Chapel Cemetery | Lothian | Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| April 15, 1950 | [signature] | Mrs. Charles E. Hicks & Son | 45 Northwest St Annapolis, Md. 72071 |

VS. A15

RECEIVED
APR 18 1950
BUREAU OF S.

D. Basil

03744

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater Post Office
STREET ADDRESS (If rural, give location): none

3. NAME OF DECEASED (Type or Print): (First) Claude (Middle) Preston (Last) STEWARD

4. DATE OF DEATH: (Month) April (Day) 22, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: January 24, 41

9. AGE last birthday: 9 yrs. — If under 1 year: Months 2, Days 10 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School boy

10b. KIND OF BUSINESS OR INDUSTRY: 3rd Grade

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Howard J. Steward

14. MOTHER'S MAIDEN NAME: Edith Octavia Leitch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): none — (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mother - Mrs Edith O. Thompson

18. MEDICAL CERTIFICATION — Edgewater, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Pulmonary Odema — 1 hr

913.0 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cellulitis right side of face — 1 week

185 (c) following puncture wound

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ✓ SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: Edgewater — (CITY OR TOWN) a a. — (COUNTY) Md. — (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY: April 14 50 7 p m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? while playing ran into broken stick

22. I hereby certify that I attended the deceased from April 15, 1950, to April 22, 1950, that I last saw the deceased alive on April 22, 1950, and that death occurred at 4 p.m., from the causes and on the date stated above.

SIGNATURE: George C. Basil — (Degree or title) MD — ADDRESS: Annapolis Md — DATE SIGNED: 4-24-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 4- 25, 1950

NAME OF CEMETERY OR CREMATORY: Edward's Chapel

LOCATION (City, town, or county) (State): Parole, A.A. Co. Maryland

DATE REC'D BY LOCAL REG.: April 25, 1950

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: B.L. Hopping and Son Annapolis, Md.

RECEIVED
APR 27 1950
BUREAU V. S.

03745

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anna Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Curtis Bay
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Curtis Bay
STREET ADDRESS (If rural, give location): Ordinance Road

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Daniel (Last) Stoll

4. DATE OF DEATH: (Month) April (Day) 2, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Oct. 3, 1875

9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Watchman Seaboard Petroleum Co.

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Stoll

14. MOTHER'S MAIDEN NAME: Louisa Radecke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Stella H. Stoll

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 **Immediate cause** (a) Cerebral thrombosis — Interval Between Onset and Death: 1 week

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio sclerotic C.V. disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Uremia

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 10, 1949, to April 2, 1950, that I last saw the deceased alive on April 1, 1950, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE: Sidney H. Gehlert — (Degree or title) M.D. — ADDRESS: 4700 Pennington Ave. — DATE SIGNED: 4/4/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 4/5/50 — NAME OF CEMETERY OR CREMATORY: Cedar Hill — LOCATION (City, town, or county) (State): Curtis Bay A.A. Co. Md.

DATE REC'D BY LOCAL REG.: April 5-50 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: John O. Mitchell & Sons Inc. — ADDRESS: 1900 Eutaw Place

602 18

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03746

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Fort George G Meade

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hours

Hospital, institution, or street address where death occurred:

Station Hospital

How long in hospital or institution? 16 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Fort George G Meade

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Station Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war: –

**3. (a) FULL NAME:** James Martin Tart

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | single |

6.(b) Name of husband or wife: –

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14, 1950

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 16 hrs. 27 min. |

9. Birthplace: Ft George G Meade Maryland (Town, county, and state)

10. Usual occupation: –

11. Industry or business: –

FATHER

12. Name: Ollie V. Tart

13. Birthplace: North Carolina

MOTHER

14. Maiden name: Betty Jane Birkhold

15. Birthplace: Ohio

16. Informant: Mrs Betty J Tart

Address: 4 Beach Walk, North Severn Naval Command, Annapolis, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-17-56 (month) (day) (year)

Cemetery or crematory: Naval Cemetery

Location: Annapolis Md.

18. Funeral director: B. L. Hopping & Son.

Address: Annapolis Md.

19. 15 Apr (Date rec'd by registrar) 50 JAMES E HAYES Capt MSC Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1956, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Never saw it alive to ..... 19.....

and that I last saw h... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| (a) Asphyxia | |
| Asphyxia | |
| Due to: atelectasis | |
| Due to: prematurity | |
| Other conditions: prematurity 7 lbs 2 oz 159 | |

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Herbert J. Jacob MD MC M.D. or other

Address: Sta Hosp Ft Meade Md Date signed: 15 Apr 1956

2-0-4-14-0-35-2-20-2

RECEIVED
APR 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

03747

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Weems Creek — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Taylor's Shore

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Gloucester St.

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Redmond (Last) Taylor III

4. DATE OF DEATH: (Month) April (Day) 15, (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | June 19, 1943 | 6 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Maryland | USA |

13. FATHER'S NAME: Robert Redmond Taylor Jr.

14. MOTHER'S MAIDEN NAME: Bessie Mae Tucker

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| No | No | None | Mrs Bessie Mae Taylor 824 Park Ave. Baltimore 1, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

929.8 **Immediate cause** (a) Accidental Drowning

183 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | Home | RFD Annapolis | Anne Arundel | Md. |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|
| 4-15-50 2:30 p m. | | fell off boat wharf into about 10 ft of water |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Lafke (Degree or title) M.D., Medical Examiner ADDRESS 98 Gloucester St. Annapolis, Md DATE SIGNED 4-15-50

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 4-18-50 | St. Mary's Cemetery | Annapolis, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| April 17, 1950 | [illegible] | B. L Hopping and Son | Annapolis, Md. |

VS-A15A

RECEIVED
APR 18 1950
BUREAU U. S.

03748

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 2 yrs. 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 228 Pearl Street

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Joseph Tyler

4. DATE OF DEATH (Month) (Day) (Year) April 22, 1950

5. SEX male

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH July 15, 1894

9. AGE last birthday 55 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Unknown

11. BIRTHPLACE (State or foreign country) West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Arthur Tyler

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No. Unknown

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) General Paresis — known to us

025X Antecedent cause(s)

30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — since 4/8/48

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/8/48, 19....., to 4/22/50, 19....., that I last saw the deceased alive on 4/22/50, 19....., and that death occurred at 3:20 a.m. from the causes and on the date stated above.

SIGNATURE Jacob Mayersohn (Degree or title) M.D. ADDRESS Crownsville, Maryland DATE SIGNED 4/22/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 4/24-50 NAME OF CEMETERY ~~OR CREMATORY~~ Hospital LOCATION (City, town, or county) (State) Crownsville Md

DATE REC'D BY LOCAL REG. 4/24/50 REGISTRAR'S SIGNATURE E. F. Joyce Local Reg.

24. FUNERAL DIRECTOR Sophia Hospital ADDRESS Crownsville Md

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 28 1950
BUREAU V. R

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03749

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 604 6th Street

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| MARY | ELIZABETH | WASHINGTON | 4-28-50 19 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 4-27-49 | 1 yrs. | 0 | 1 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Annapolis, Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Clarence M Washington | Mildred E. Cox |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no none | none | Mr. Clarence M. Washington, Eastport, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Septicemia — 2 days

492x

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Varicella pneumonia — 2 days

109

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 4-28 10AM, 19 50, to 4-28 1PM, 19 50, that I last saw the deceased alive on 4-28, 19 50, and that death occurred at 1 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Geo C Burch | M. D. | Annapolis Md | 4-30-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 5-1-50 | Glen Haven Cemetery | Glen Burnie, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| May 1, 1950 | [signature] | B.L Hopping and Son | Annapolis, Md. |

RECEIVED
MAY 2 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03750

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A. |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 2 weeks | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 1312 West St. | STREET ADDRESS (If rural, give location) |

| | |
|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) Lavinia (Middle) Phipps (Last) Witt | 4. DATE OF DEATH (Month) April (Day) 17/50 (Year) 19 |
| 5. SEX Female — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 15/74 — 9. AGE last birthday 76 yrs. — If under 1 year Months Days — If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY Housewife | 11. BIRTHPLACE (State or foreign country) Sudley, A.A.Co. — 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William Phipps | 14. MOTHER'S MAIDEN NAME Laura Levy |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If year, give war or dates of service) no — 16. SOCIAL SECURITY No. none | 17. INFORMANT AND ADDRESS Lavine Hartge, Shadyside, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arterio Sclerosis generalized — 3 years

Antecedent cause(s) (b) with Marked Cerebral Sclerosis

334x 97

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertension — 3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Jm, 1947, to April 17, 1950, that I last saw the deceased alive on April 16, 1950, and that death occurred at 9 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| George C Basil | M. D. | Annapolis Md | 4-17.50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 4/20/50 | NAME OF CEMETERY OR CREMATORY Quaker | LOCATION (City, town, or county) (State) Galesville, Md. |
| DATE REC'D BY LOCAL REG. April 18, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR T.A.Hardesty & Son | ADDRESS Galesville, Md |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
APR 19 1950

03751

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 2 yr. 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 526 Eislen Street

3. NAME OF DECEASED (Type or Print) (First) Emma (Middle) (Last) Wright
4. DATE OF DEATH (Month) 4/18/50 (Day) (Year) 19

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH: about 1889 not known
9. AGE last birthday: 60 (?) yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): not known
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Hospital Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — INTERVAL BETWEEN ONSET AND DEATH: known since 12/12/47

025 x

Antecedent cause(s)

30d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 12/12/47, 19....., to 4/18/50, 19....., that I last saw the deceased alive on 4/18/50, 19....., and that death occurred at 3:40 A. m., from the causes and on the date stated above.

SIGNATURE: Jacob Marycuster (Degree or title) M.D. — ADDRESS: Crownsville, Md. — DATE SIGNED: 4/19/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 4/19/50 — NAME OF CEMETERY ~~OR CREMATORY~~: Hospital — LOCATION (City, town, or county) (State): Crownsville Md. a.a. Co.

DATE REC'D BY LOCAL REG.: 4/19/50 — REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg.

24. FUNERAL DIRECTOR: Supt Hospital — ADDRESS: Crownsville Md

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

03752

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. Co. STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey
LENGTH OF STAY (in this place) 70 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Race Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey
STREET ADDRESS (If rural, give location) Race Rd.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) H. (Last) Wright

4. DATE OF DEATH: (Month) 13th April (Day) (Year) 1950

5. SEX Male | 6. COLOR OR RACE Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH July 10, 1878 | 9. AGE last birthday 71 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY R.R. | 11. BIRTHPLACE (State or foreign country) P. G. Co. Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.a.

13. FATHER'S NAME Alfred a. Wright | 14. MOTHER'S MAIDEN NAME Carolina ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. ? | 17. INFORMANT Wilbur Wright, Dorsey, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Tongue — Interval Between Onset and Death: 2 yrs.

141 x 45 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1/50, 19..., to 4/13/50, 19..., that I last saw the deceased alive on 4/13/50, 19..., and that death occurred at 9-P. m., from the causes and on the date stated above.

SIGNATURE Frank Shipley, M.D. (Degree or title) ADDRESS Savage, Md. DATE SIGNED 4/14/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 4/16/50 | NAME OF CEMETERY OR CREMATORY St. Mark's, Ridge | LOCATION (City, town, or county) M. E. A. A. Co. | (State) Md.

DATE REC'D BY LOCAL REG. April 14-50 | REGISTRAR'S SIGNATURE Clara Caslick | 24. FUNERAL DIRECTOR Kate Williams, Schroeder & Mullaney | ADDRESS Baltimore, Md.

78847

RECEIVED
APR 20 1950
BUREAU V. S.